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<b>State:</b>	District of Columbia	<b>Filing Company:</b>	Guarantee Trust Life Insurance Company
<b>TOI/Sub-TOI:</b>	L08 Life - Other/L08.000 Life - Other		
<b>Product Name:</b>	APPL 1-16		
<b>Project Name/Number:</b>	APPL 1-16/APPL1-16		

## Filing at a Glance

Company:	Guarantee Trust Life Insurance Company
Product Name:	APPL1-16
State:	District of Columbia
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	11/08/2016
SERFF Tr Num:	GRTT-130800047
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	APPL1-16
Implementation	On Approval
Date Requested:	
Author(s):	Gillian Liang, Paul Porcaro, Ann Ryan
Reviewer(s):	John Rielley (primary)
Disposition Date:	
Disposition Status:	
Implementation Date:	

State: District of Columbia Filing Company: Guarantee Trust Life Insurance Company  
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other  
 Product Name: APPL 1-16  
 Project Name/Number: APPL 1-16/APPL1-16

## General Information

Project Name: APPL1-16 Status of Filing in Domicile: Pending  
 Project Number: APPL1-16 Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments:  
 Explanation for Combination/Other: Market Type: Individual  
 Submission Type: New Submission Individual Market Type:  
 Overall Rate Impact: Filing Status Changed: 11/10/2016  
 State Status Changed:  
 Deemer Date: Created By: Gillian Liang  
 Submitted By: Gillian Liang Corresponding Filing Tracking Number:

Filing Description:  
 RE:Guarantee Trust Life Insurance Company  
 NAIC No. 687-64211  
 FEIN No. 36-1174500  
 Individual Life Insurance

Dear Reviewer:

We are submitting life application form APPL1-16 for your Department's consideration and approval.

This form is new and will not replace any previously approved form.

Application APPL1-16 has been designed to allow the agent to make an initial determination of the applicant's eligibility, and to assist the applicant in choosing the plan for which he or she qualifies. We would appreciate general approval of this application so that it may be used with life policies approved by your state.

The bracketed information in the application are variable. It is not our intention to make any changes that would cause this application to be out of compliance with any statutory requirements.

We are submitting for informational purposes the updated actuarial memorandum and schedule page for previously approved life policy form 90GBL, approved by your department on May 5, 1991. The actuarial memorandum has been updated with the 2013 reduction in the maximum valuation and nonforfeiture interest rate. The cash value interest rate is shown on the schedule page.

We certify that the above form will not be illustrated.

This form may be computer generated and laser printed, or digitally reproduced. We reserve the right to use a different typeset/font/font size consistent with state requirements.

We would appreciate any consideration you could extend toward prompt approval of this filing. If I can be of further assistance in this approval process, please feel free to call me toll free at 800-338-7452, ext. 5410, or call me direct at 847-904-5410, or e-mail me at [glian@gtlic.com](mailto:glian@gtlic.com).

Sincerely,

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<b>TOI/Sub-TOI:</b>	L08 Life - Other/L08.000 Life - Other		
<b>Product Name:</b>	APPL 1-16		
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Gillian Liang  
Senior Compliance Analyst  
Product Approval and Compliance (PAC)

## Company and Contact

### Filing Contact Information

Gillian Liang, Senior Compliance Analyst	glian@gtlic.com
1275 Milwaukee Ave.	847-904-5410 [Phone]
Glenview, IL 60025	847-699-0093 [FAX]

### Filing Company Information

Guarantee Trust Life Insurance Company	CoCode: 64211	State of Domicile: Illinois
1275 Milwaukee Avenue	Group Code: 687	Company Type: Mutual
1275 Milwaukee Avenue	Group Name:	State ID Number:
Glenview, IL 60025	FEIN Number: 36-1174500	
(847) 460-4772 ext. [Phone]		

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## Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	

<b>State:</b>	District of Columbia	<b>Filing Company:</b>	Guarantee Trust Life Insurance Company
<b>TOI/Sub-TOI:</b>	L08 Life - Other/L08.000 Life - Other		
<b>Product Name:</b>	APPL1-16		
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## Form Schedule

Lead Form Number: APPL1-16								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application	APPL1-16	AEF	Initial		46.000	APPL1-16 final.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

<b>PROPOSED INSURED</b>		<b>SEND DOCUMENTS TO: <input type="checkbox"/> AGENT <input type="checkbox"/> INSURED</b>	
Last Name _____ First Name _____ M.I. _____			
Home Address _____ City _____ State _____ Zip _____			
Phone Work ( ) _____ Home ( ) _____ Occupation _____			
Social Security Number _____ <input type="checkbox"/> Male <input type="checkbox"/> Female Age _____ Date of Birth(mm/dd/yy) _____			
Weight _____ lbs. Height _____ ft. _____ in. E-mail address _____			
Requested Effective Date* _____ Requested Draft Date* _____			
<i>*Draft day cannot be more than 10 days before or after the effective date.</i>			
<b>Plan applied for:</b> <input type="checkbox"/> Level Death Benefit Face Amount \$ _____ <input type="checkbox"/> Graded Death Benefit Face Amount \$ _____		<b>Model Premium</b> <input type="checkbox"/> Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi Annual <input type="checkbox"/> Monthly PAC	
		<b>Amount of Premium Collected:</b> \$ _____	
Is Automatic Premium Loan Desired? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Owner (Complete only if other than Proposed Insured)</b>			
Full legal name of individual _____ (First, Middle, Last), Institution or Trust			
Street Address _____ City _____ State _____ Zip _____			
Home Phone Number _____ Alternate Phone/Cell Number _____			
Relationship to the proposed insured _____ Date of Birth (mm/dd/yy) _____ Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			
Social Security/Tax ID Number _____			
<b>Beneficiary Information (Revocable)</b>			
Name of each primary beneficiary (Last, First, Middle Initial)		Relationship to Insured	
Name of each contingent beneficiary (Last, First, Middle Initial)		Relationship to Insured	
Will the proposed insurance replace any existing life insurance policies or annuities? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes", please provide the company name and submit necessary replacement forms. _____			
Has the proposed insured used any Tobacco products in the last 12 months?			<input type="checkbox"/> Yes <input type="checkbox"/> No
1. Is the proposed insured currently confined to a hospital, psychiatric, nursing or correctional facility, or receiving home health care or receiving or been advised to receive hospice care?			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does the proposed insured currently use a wheelchair or require assistance with activities of daily living such as bathing, dressing, eating, moving from chair to bed or toileting, or require assistance in taking medications?			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has the proposed insured had, been diagnosed as having, received medication for or been treated or advised to have treatment by a medical professional for:			
a. Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive to the Human Immunodeficiency Virus (HIV)?			<input type="checkbox"/> Yes <input type="checkbox"/> No

b. Alzheimer's disease, dementia, Amyotrophic Lateral Sclerosis (ALS), Huntington's disease, cystic fibrosis, organ or tissue transplant (other than corneal) or a terminal illness (life expectancy less than 12 months)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 12 months has the proposed insured used, been advised by a medical professional to use oxygen to assist in breathing or require dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Within the past 12 months has the proposed insured had any abnormal diagnostic test results, awaiting test results, require home health care or hospitalization which has not yet begun, or been advised to have any diagnostic test, or had a medical condition, symptom or abnormality that would have caused a person to seek medical attention or advice but has not yet done so?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has the proposed insured had, been diagnosed as having, received medication for or been treated or advised to have treatment by a medical professional for:	
a. High blood pressure not currently under control; or have a pacemaker or defibrillator?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Substance use, abuse or addiction for alcohol or drugs, either illicit or prescription within the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Insulin shock or diabetic coma in the past 2 years or had an amputation due to complications of diabetes or used insulin prior to age 50 to treat diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Heart or circulatory surgery, heart attack, congestive heart failure, cardiomyopathy, stroke, Transient Ischemic Attack (TIA), or aneurysm within the past 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Cancer (excluding basal cell skin cancer) or brain tumor within the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If the answer to questions 1-6 is YES, the applicant does not qualify for any coverage.</i>	
7. Within the past 2 years has the proposed insured had, been diagnosed as having, received medication for or been treated or advised to have treatment by a medical professional for:	
a. Parkinson's disease, Systemic Lupus Erythematosus (SLE), muscular dystrophy, multiple sclerosis, cirrhosis of the liver, chronic hepatitis or other liver disorder, kidney failure, or other chronic kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Chronic Obstructive Lung/Pulmonary Disease (COPD/COLD), emphysema or chronic bronchitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If questions 1-6 are answered NO and question 7 is answered YES, the applicant qualifies for the Graded Plan.</i>	
<i>If questions 1-7 are answered NO, the applicant qualifies for the Level Plan.</i>	

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Guarantee Trust Life Insurance Company (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my physical condition, other coverage and criminal or motor vehicle records needed to underwrite my application for insurance. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes,) such information or records from any doctor, health professional, hospital, clinic, the Veterans Administration, insurance company, pharmacy benefit manager, pharmacies or pharmacy-related facility which have such information including any medical information provided to any affiliate insurance company on previous applications and medical information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from MIB, Inc. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. This Authorization includes all information about drugs, alcoholism, and mental illness. I understand and agree that the Company or its representatives may conduct a phone interview or face-to face assessment as part of the underwriting process. Although federal regulations require that the Company inform me of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. I agree this authorization will be valid for 24 months from the date signed. I or my authorized representative may have a photocopy of it. I have read or had read this authorization and I have also received a copy or will be provided a copy of the "Notice to Applicant, Parts 1 and 2" and the Description of Information Practices form prepared by Guarantee Trust Life Insurance Company (if required by your state).

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or so long as GTL has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my agent or to the attention of the Underwriting Manager. I understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by GTL in accordance with federal or state law. I also understand that my application for insurance can be declined if I choose not to sign this Authorization.

This application may be completed by electronic or telephonic means. I acknowledge that the Company or its agent has verified my identity for this purpose in accordance with any applicable law or regulation and that if completed by electronic means, I have provided my consent and authorization to complete an electronic transaction to apply for coverage.

This authorization shall constitute an electronic signature, which is legally binding, and has the same effect as if I had physically signed this application. If this application is completed by phone, I authorize the Company or its agent to accept my voice signature response.

[I agree that I may receive my policy and other GTL correspondence in electronic format. I acknowledge receipt of the Electronic Delivery and Communications Disclosure, which describes the requirements for Electronic Policy Fulfillment and Communications, as well as my right to opt-out of Electronic Policy Fulfillment and receive a paper copy of my policy free of charge.]

### Fraud warnings

General fraud warning: Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance, containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material there to commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of the State(s) listed below, please note the following:

**For AL** the following warning applies: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**For AR, DC, LA, MA, NM, RI, and WV** the following fraud warning applies: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For CO the following warning applies:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**For FL the following notice applies:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**For KS the following notice applies:** Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.

**For KY the following notice applies:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance, containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material there to commits a fraudulent insurance act, which is a crime.

**For MD the following notice applies:** Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For ME, TN, VA, and WA the following notice applies:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**For NJ the following notice applies:** Any person who knowingly includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**For OH the following notice applies:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**For OK the following notice applies:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**For OR the following notice applies:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**For VT the following notice applies:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I certify that I have asked all questions and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, the insurance applied for ☐ is likely, or ☐ is not likely to replace or change existing insurance or annuities.

X \_\_\_\_\_  
Signature of Soliciting Agent Agent No.  
(Agent's signature not required if not sold through agent)

Signed at \_\_\_\_\_  
City State/Zip Date

\_\_\_\_\_  
Print Agent Name Above Agent E-mail Address

I hereby agree that: (1) all statements and answers in this application are complete and true, to the best of my knowledge and belief; and (2) no insurance will be effective until the policy is issued by the Company. I understand that if I have selected a Graded Death Benefit Plan, the benefit will be limited for an initial period and will remain level thereafter.

X \_\_\_\_\_  
Signature of Proposed Insured

X \_\_\_\_\_  
Signature of Owner (if other than Proposed Insured)



<b>SERFF Tracking #:</b>	GRTT-130800047	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	APPL1-16
<b>State:</b>	District of Columbia	<b>Filing Company:</b>	Guarantee Trust Life Insurance Company		
<b>TOI/Sub-TOI:</b>	L08 Life - Other/L08.000 Life - Other				
<b>Product Name:</b>	APPL1-16				
<b>Project Name/Number:</b>	APPL1-16/APPL1-16				

## Supporting Document Schedules

<b>Satisfied - Item:</b>	90GBL Actuarial memorandum and Schedule page 3B with cash value interest rate
<b>Comments:</b>	
<b>Attachment(s):</b>	Actuarial Memorandum 90GBL 2016.pdf 90GBL Schedule page 3B.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	
<b>Satisfied - Item:</b>	Statement of variability
<b>Comments:</b>	
<b>Attachment(s):</b>	STATEMENT OF VARIABILITY.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

**Guarantee Trust Life Insurance Company**  
**Actuarial Memorandum**  
**Form 90GBL**

**Description**

This a whole life policy with a reduced death benefit the first two years and level premiums for life. The first year death benefit is equal \$300. The second year death benefit is equal \$700. The third and later years death benefit is \$1,000.

**Reserve Basis**

Method: CRVM

Table: 2001 CSO ALB , Male/Female, Composite

Interest Rate: Maximum according to the SVL, currently 3.50%

Reserves assume immediate payment of claims.

**Nonforfeiture Basis**

Method: Cash surrender values are minimum according to the SNFL

Table: 2001 CSO ALB , Male/Female, Composite

Interest Rate: Maximum according to SNFL, currently 4.50%

Extended Term and Reduced Paid Up values are based on the same table and interest rate.

**Terminal Reserve Formula**

$${}_tV_x = 0 \quad \text{for } t = 0, 1$$

$${}_tV_x = PVB_{x+t} - \beta^{CRVM} \ddot{a}_{x+t} \quad \text{for } t > 1$$

Where:

$$PVB_{x+t} = \frac{i}{\delta} \sum_{k=0}^{\infty} {}_{k+1}DB_{x+t} (v^{k+1} {}_k p_{x+t} * q_{x+t+k})$$

$$\beta^{CRVM} = P + \frac{\text{Min}[\beta^F, ELRA_{19} P_{x+1}] - DB_1 v q_x}{\ddot{a}_x}$$

$$ELRA = \frac{\sum_{t=2}^{10} DB_t}{9}$$

P is the net premium for this plan of insurance.  $\beta^F$  is the FPT renewal net premium for this plan of insurance.  ${}_{19}P_{x+1}$  is the FPT renewal net premium for a level benefit, 20-pay, whole life insurance.

### Example of Reserves for Age 35 Male

Terminal Reserves for the first 20 years are shown below

i/delta				1.01740						
Endowment				1,000						
Net Single Premium				262.6801						
Annuity Factor				21.9252						
ELRA				966.6667						
GP Annuity Factor				21.9252						
Renewal Net Premium				11.9807						
1st Yr Net Premium				0.3657						

Issue Age		35				
Table		6		2001CSOMAL		
Interest Rate		3.50%				
Issue Age +1		36				
Expire Age		121				
Endowment		1000				
Endow Age		121				

				Mortality Rate	Survivorship	Int Disc Factors	PV Endowment	Net Single Premium	Renewal NP (Beta)	PV Beta	Terminal Reserve
x+t-1	t-1	Death Benefit	Gross Premium Ratio	qx+t-1	tPx	v(t+1)	0.0000	262.6801	11.981	262.6801	-
35	0	300	1.00	0.00124							0.00
36	1	700	1.00	0.00131	1.000000	0.966184	0.0000	271.2963	11.981	259.8142	11.48
37	2	1,000	1.00	0.00139	0.998690	0.933511	0.0000	279.7664	11.981	256.8646	22.90
38	3	1,000	1.00	0.00149	0.997302	0.901943	0.0000	288.4721	11.981	253.8331	34.64
39	4	1,000	1.00	0.00159	0.995816	0.871442	0.0000	297.4238	11.981	250.7158	46.71
40	5	1,000	1.00	0.00172	0.994232	0.841973	0.0000	306.6111	11.981	247.5165	59.09
41	6	1,000	1.00	0.00187	0.992522	0.813501	0.0000	316.0309	11.981	244.2363	71.79
42	7	1,000	1.00	0.00205	0.990666	0.785991	0.0000	325.6740	11.981	240.8783	84.80
43	8	1,000	1.00	0.00227	0.988636	0.759412	0.0000	335.5247	11.981	237.4480	98.08
44	9	1,000	1.00	0.00252	0.986391	0.733731	0.0000	345.5751	11.981	233.9482	111.63
45	10	1,000	1.00	0.00277	0.983906	0.708919	0.0000	355.8377	11.981	230.3745	125.46
46	11	1,000	1.00	0.00303	0.981180	0.684946	0.0000	366.3192	11.981	226.7245	139.59
47	12	1,000	1.00	0.00325	0.978207	0.661783	0.0000	377.0593	11.981	222.9845	154.07
48	13	1,000	1.00	0.00342	0.975028	0.639404	0.0000	388.1042	11.981	219.1384	168.97
49	14	1,000	1.00	0.00364	0.971693	0.617782	0.0000	399.4385	11.981	215.1915	184.25
50	15	1,000	1.00	0.00391	0.968156	0.596891	0.0000	411.0480	11.981	211.1487	199.90
51	16	1,000	1.00	0.00426	0.964371	0.576706	0.0000	422.9021	11.981	207.0208	215.88
52	17	1,000	1.00	0.00470	0.960263	0.557204	0.0000	434.9662	11.981	202.8197	232.15
53	18	1,000	1.00	0.00521	0.955750	0.538361	0.0000	447.2194	11.981	198.5528	248.67
54	19	1,000	1.00	0.00583	0.950770	0.520156	0.0000	459.6202	11.981	194.2345	265.39

### **Cash Value Formula**

$${}_t CV_x = A_{x+t} - P^a \ddot{a}_{x+t}$$

Where:

$$A_{x+t} = \sum_{k=0}^{\infty} {}_{k+1}DB_{x+t} (v^{k+1} {}_k p_{x+t} * q_{x+t+k})$$

$$P_x^a = \frac{A_x + .01 * ELA + 1.25 * \text{Min}[P_x^{NLP}, .04 * ELA]}{\ddot{a}_x}$$

$$P_x^{NLP} = \frac{A_x}{\ddot{a}_x}$$

$$ELA = \frac{\sum_{t=1}^{10} DB_t}{10}$$

### **Reduced Paid Up**

$${}_t RPU_x = \frac{{}_t CV_x}{A_{x+t}}$$

### **Extended Term**

The Extended Term period is determined as the solution for n

$$A_{x+t;n} = {}_t CV_x$$

### Example of Cash Values for Age 35 Male

Cash Values for the first 20 years are shown below

Endowment	1,000.00								
Net Single Premium	176.085								
PV Endowment	0.0000								
Level Annuity Factor	19.106								
Nonforfeiture Net Level Prem	9.216450								
Average Amt Insurance	900.000								
Expense Allowance	20.52056								
Gross Premium Annuity Factor	19.10550								
Adjusted Premium	10.291								
					PV Endowment	Net Single Premium	NF Factor	PV NF Factor	
<b>x+t-1</b>	<b>t</b>	<b>Benefit</b>	<b>NFF Ratio</b>	<b>qx+t-1</b>	<b>0.0000</b>	<b>176.0849</b>	<b>10.291</b>	<b>196.6055</b>	<b>Cash Value</b>
35	1	300	1.00	0.00124	0.0000	183.8647	10.291	194.9409	(11.08)
36	2	700	1.00	0.00131	0.0000	191.4725	10.291	193.2127	(1.74)
37	3	1,000	1.00	0.00139	0.0000	198.9753	10.291	191.4198	7.56
38	4	1,000	1.00	0.00149	0.0000	206.7473	10.291	189.5625	17.18
39	5	1,000	1.00	0.00159	0.0000	214.8024	10.291	187.6376	27.16
40	6	1,000	1.00	0.00172	0.0000	223.1323	10.291	185.6470	37.49
41	7	1,000	1.00	0.00187	0.0000	231.7366	10.291	183.5909	48.15
42	8	1,000	1.00	0.00205	0.0000	240.6080	10.291	181.4709	59.14
43	9	1,000	1.00	0.00227	0.0000	249.7323	10.291	179.2905	70.44
44	10	1,000	1.00	0.00252	0.0000	259.1032	10.291	177.0511	82.05
45	11	1,000	1.00	0.00277	0.0000	268.7372	10.291	174.7489	93.99
46	12	1,000	1.00	0.00303	0.0000	278.6447	10.291	172.3813	106.26
47	13	1,000	1.00	0.00325	0.0000	288.8725	10.291	169.9372	118.94
48	14	1,000	1.00	0.00342	0.0000	299.4760	10.291	167.4033	132.07
49	15	1,000	1.00	0.00364	0.0000	310.4424	10.291	164.7826	145.66
50	16	1,000	1.00	0.00391	0.0000	321.7604	10.291	162.0780	159.68
51	17	1,000	1.00	0.00426	0.0000	333.3999	10.291	159.2965	174.10
52	18	1,000	1.00	0.00470	0.0000	345.3259	10.291	156.4466	188.88
53	19	1,000	1.00	0.00521	0.0000	357.5183	10.291	153.5330	203.99

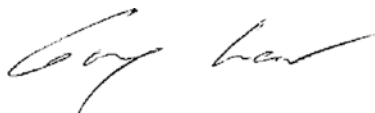
Cash values are rounded to the high dollar.

Reduced Paid Up amount at the end of the 5<sup>th</sup> policy year rounded to high dollar

$$\frac{28.00}{.2148024} = 131.00$$

Extended Term period at the end of the 5<sup>th</sup> policy year is: n= 13 years, 70 days

$$A_{40:n} = 28.00$$



Grigori Lev, FSA, MAAA  
Guarantee Trust Life Insurance Company  
November 4, 2016

GUARANTEE TRUST LIFE INSURANCE COMPANY

SCHEDULE  
TABLE OF GUARANTEED POLICY VALUES

END OF POLICY YEAR	CASH VALUE	AMOUNT OF REDUCED PAID UP INSURANCE
1	\$0	\$0
2	\$0	\$0
3	\$80	\$410
4	\$180	\$880
5	\$280	\$1,310
6	\$380	\$1,710
7	\$490	\$2,120
8	\$600	\$2,500
9	\$710	\$2,850
10	\$830	\$3,210
11	\$940	\$3,500
12	\$1,070	\$3,850
13	\$1,190	\$4,120
14	\$1,330	\$4,450
15	\$1,460	\$4,710
16	\$1,600	\$4,980
17	\$1,750	\$5,250
18	\$1,890	\$5,480
19	\$2,040	\$5,710
20	\$2,200	\$5,950
AGE 60	\$3,010	\$6,920
AGE 70	\$4,790	\$8,280

NON-FORFEITURE FACTOR: 10.29

THE CASH VALUES AND FACTORS REFERRED TO IN THIS POLICY ARE BASED ON THE COMMISSIONERS 2001 STANDARD ORDINARY MORTALITY TABLE AND 4.50% INTEREST.

INSURED  
JOHN DOE, SR.

AGE  
35

SEX  
MALE

POLICY NUMBER  
1,234,567

**Guarantee Trust Life Insurance Company**  
**STATEMENT OF VARIABILITY**

November 3, 2016

Form Number: APPL1-16

DOCUMENT (Form #)	BRACKETED ITEM	VARIABILITY
APPL1-16	<i>[Marketing Name of Life Insurance Product.]</i>	Assigned Marketing name will be shown. If there is no marketing name for the product, this will not appear.
	<i>[1275 Milwaukee Avenue, Glenview, IL 60025 (800)338-7452]</i>	We have bracketed the company's address and phone number in the event we move or need to change our telephone number.
	<i>Plan applied for:</i> <input type="checkbox"/> <i>Level Death Benefit    Face Amount</i> <i>\$ _____]</i> <input type="checkbox"/> <i>Graded Death Benefit    Face Amount</i> <i>\$ _____]</i>	Type of life insurance product offered to the consumer will be shown.
	<i>[I agree that I may receive my policy and other GTL correspondence in electronic format. I (We) acknowledge receipt of the Electronic Delivery and Communications Disclosure, which describes the requirements for Electronic Policy Fulfillment and Communications, as well as my (our) right to opt-out of Electronic Policy Fulfillment and receive a paper copy of my policy free of charge.]</i>	Bracketed to allow for removal of this section if electronic fulfillment is not offered.